Documentation, Coding and Billing in PALTC:2024

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Best Care Practices In the Post-Acute & Long-Term Care Continuum

fmda The Florida Society For Post-Acute and Long-Term Care Medicine

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Speaker Disclosures

Dr. Zorowitz is an employee and stockholder of Humana, Inc.

The opinions presented in this presentation represent those of Dr. Zorowitz and do not represent the positions of Humana

All financial relationships have been identified, reviewed, and mitigated by The Society prior to this presentation.

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Learning Objectives

By the end of the session, participants will be able to:

- Understand the E&M guidelines for Nursing Facilities and Home/Residence Services
- Understand the Medical Decision-Making criteria
- Be familiar with reporting prolonged services
- Be familiar with reporting Split/Shared Services
- Understand the distinction between CMS payment policy and federal statutory regulations

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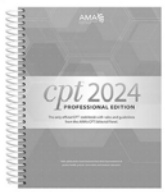
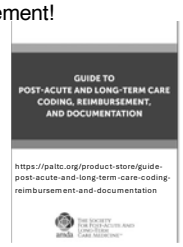
Tip for Accurate Coding: Know Your Codes and Reimbursement!





Medicare Physician Fee Schedule Lookup: https://www.cms.gov/medicare/physician-fee-schedule/search

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Choosing Level of Care for E&M Services

Select the appropriate level of E/M services based on the following:

The level of the MDM as defined for each service ◀ OR ▶ The total time for E/M services performed on the date of the encounter.

From 8/9/2022 Webinar L. Levy, B. Hollmann P. "E/M 2023: Advancing Landmark Revisions Across More Settings of Care," downloaded on 10/2/2022 from https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

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1. History and Physical Examination

- Must be performed and documented as clinically appropriate
- No longer an element in the selection of the level of E&M service codes
- No need to document gratuitous reviews of systems for the purpose of claims unless performed or reviewed as clinically appropriate
- Remain important activities clinically and to support medical necessity of the service

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2. Time

Total time on the date of the encounter,

To select the level based on time, the indicated total time must be met or exceeded

Includes both face-to-face time *with the patient* and/or family/caregiver and non-face-to-face time (must include a face-to-face encounter)

Includes time regardless of location

Do not count time spent on:

- Travel
- General teaching not limited to discussion that is required for the management of a specific patient
- Other services that are reported separately

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E&M Total Time Spent on Calendar Day of the Encounter

Pre-visit

- Preparing to see patient, review of tests
- Independently reviewing results and communicating results to patient/caregiver

Visit

- Obtaining/reviewing separate history
- Performing exam and evaluation
- Counseling/educating patient and caregiver

Post-visit

- Ordering medications, tests
- Documentation in EMR
- Referring or communicating with other HCP (not separately reported)
- Care coordination (not separately reported)

Document: *"I personally spent ____ minutes on the calendar day of the encounter, including pre and post visit work."*

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3. Medical Decision Making 2024

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

- To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded
- The details and examples of Medical Decision-Making are described entirely in the 2024 CPT Manual

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Type of Medical Decision Making By Components

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate ←	Moderate	Moderate	Moderate
High	High	Extensive	High

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Type of Medical Decision Making By Components

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Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate ←	Moderate	Moderate	Moderate
High	High	Extensive	High

- To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded
- The details and examples of Medical Decision-Making are described entirely in the 2024 CPT Manual

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Why learn Medical Decision Making when I can use time?

HCPCS Code	Short Description	Total Time in Minutes*	Medical Decision Making	Price (2024)	Work RVU
99304	1st nf care sf/low mdm 25	25	Straightforward or low	$78.26	1.5
99305	1st nf care moderate mdm 35	35	Moderate	$129.99	2.5
99306	1st nf care high mdm 50	50	High	$177.47	3.5
99307	Sbsq nf care sf mdm 10	10	Straightforward	$39.29	0.7
99308	Sbsq nf care low mdm 20	20	Low	$72.69	1.3
99309	Sbsq nf care moderate mdm 30	30	Moderate	$105.11	1.92
99310	Sbsq nf care high mdm 45	45	High	$149.97	2.8

*Note highlighted times were increased by 5 minutes over 2023 Total Time
Price is National Payment Amount

2024 conversion factor is $32.74 per RVU

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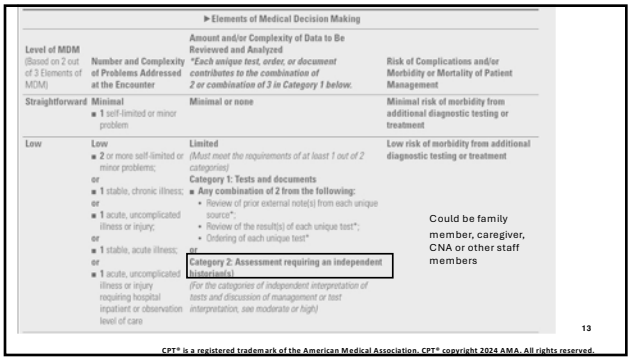
►Elements of Medical Decision Making
Level of MDM (Based on 2 out of 3 Elements of MDM)
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward
Minimal
■ 1 self-limited or minor problem
Minimal or none
Minimal risk of morbidity from additional diagnostic testing or treatment
Low
Low
■ 2 or more self-limited or minor problems;
or
■ 1 stable, chronic illness;
or
■ 1 acute, uncomplicated illness or injury;
or
■ 1 stable, acute illness;
or
■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
Limited
(Must meet the requirements of at least 1 out of 2 categories)
Category 1: Tests and documents
■ Any combination of 2 from the following:
• Review of prior external note(s) from each unique source*;
• Review of the result(s) of each unique test*;
• Ordering of each unique test*
or
Category 2: Assessment requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
Low risk of morbidity from additional diagnostic testing or treatment
Could be family member, caregiver, CNA or other staff members
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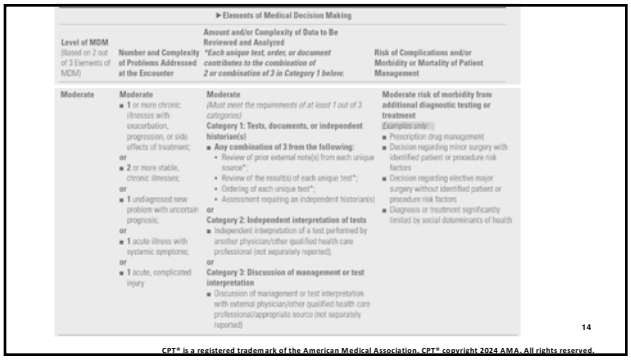
►Elements of Medical Decision Making
Level of MDM (Based on 2 out of 3 Elements of MDM)
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate
Moderate
■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
or
■ 2 or more stable, chronic illnesses;
or
■ 1 undiagnosed new problem with uncertain prognosis;
or
■ 1 acute illness with systemic symptoms;
or
■ 1 acute, complicated injury
Moderate
(Must meet the requirements of at least 1 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
■ Any combination of 3 from the following:
• Review of prior external note(s) from each unique source*;
• Review of the result(s) of each unique test*;
• Ordering of each unique test*;
• Assessment requiring an independent historian(s)
or
Category 2: Independent interpretation of tests
■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
or
Category 3: Discussion of management or test interpretation
■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Moderate risk of morbidity from additional diagnostic testing or treatment
Examples only:
■ Prescription drug management
■ Decision regarding minor surgery with identified patient or procedure risk factors
■ Decision regarding elective major surgery without identified patient or procedure risk factors
■ Diagnosis or treatment significantly limited by social determinants of health
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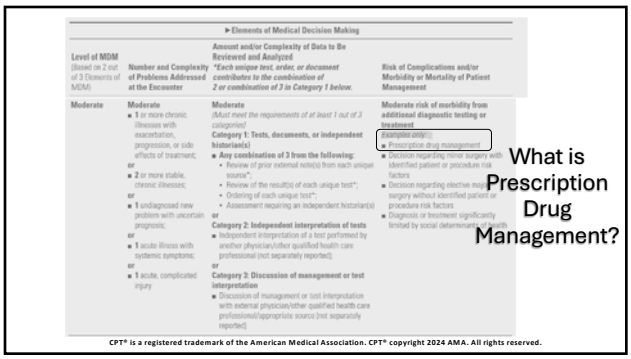
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Level of MDM (Based on 2 out of 3 Elements of MDM)
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate
Moderate
■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
or
■ 2 or more stable, chronic illnesses;
or
■ 1 undiagnosed new problem with uncertain prognosis;
or
■ 1 acute illness with systemic symptoms;
or
■ 1 acute, complicated injury
Moderate
(Must meet the requirements of at least 1 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
■ Any combination of 3 from the following:
• Review of prior external note(s) from each unique source*;
• Review of the result(s) of each unique test*;
• Ordering of each unique test*;
• Assessment requiring an independent historian(s)
or
Category 2: Independent interpretation of tests
■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
or
Category 3: Discussion of management or test interpretation
■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Moderate risk of morbidity from additional diagnostic testing or treatment
Examples only:
■ Prescription drug management
■ Decision regarding minor surgery with identified patient or procedure risk factors
■ Decision regarding elective major surgery without identified patient or procedure risk factors
■ Diagnosis or treatment significantly limited by social determinants of health
What is Prescription Drug Management?
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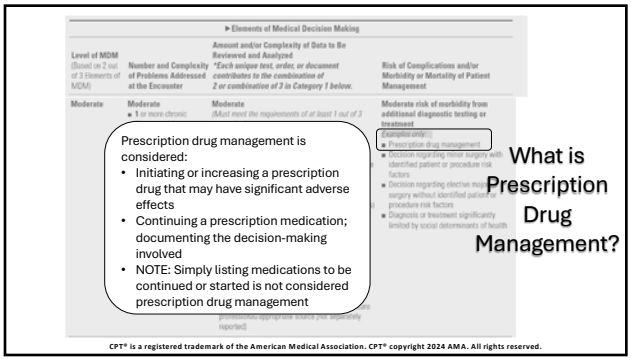
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Level of MDM (Based on 2 out of 3 Elements of MDM)
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to Be Reviewed and Analyzed
*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate
Moderate
■ 1 or more chronic
Moderate
(Must meet the requirements of at least 1 out of 3
Moderate risk of morbidity from additional diagnostic testing or treatment
Examples only:
■ Prescription drug management
■ Decision regarding minor surgery with identified patient or procedure risk factors
■ Decision regarding elective major surgery without identified patient or procedure risk factors
■ Diagnosis or treatment significantly limited by social determinants of health
Prescription drug management is considered:
• Initiating or increasing a prescription drug that may have significant adverse effects
• Continuing a prescription medication; documenting the decision-making involved
• NOTE: Simply listing medications to be continued or started is not considered prescription drug management
What is Prescription Drug Management?
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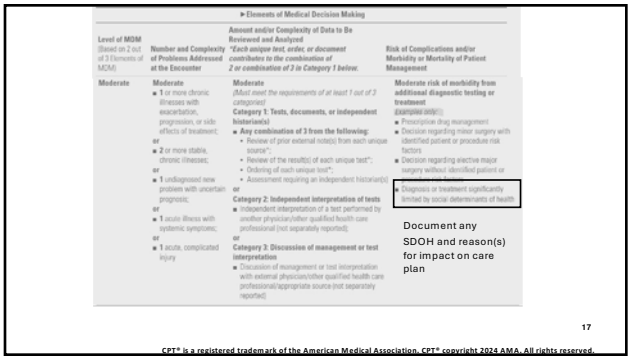
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Level of MDM (Based on 2 out of 3 Elements of MDM)
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to Be Reviewed and Analyzed
*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate
Moderate
■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
or
■ 2 or more stable, chronic illnesses;
or
■ 1 undiagnosed new problem with uncertain prognosis;
or
■ 1 acute illness with systemic symptoms;
or
■ 1 acute, complicated injury
Moderate
(Must meet the requirements of at least 1 out of 3 categories)
Category 1: Tests, documents, or independent historian(s)
■ Any combination of 3 from the following:
• Review of prior external note(s) from each unique source*;
• Review of the result(s) of each unique test*;
• Ordering of each unique test*;
• Assessment requiring an independent historian(s)
or
Category 2: Independent interpretation of tests
■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
or
Category 3: Discussion of management or test interpretation
■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
Moderate risk of morbidity from additional diagnostic testing or treatment
Examples only:
■ Prescription drug management
■ Decision regarding minor surgery with identified patient or procedure risk factors
■ Decision regarding elective major surgery without identified patient or
■ Diagnosis or treatment significantly limited by social determinants of health
Document any SDOH and reason(s) for impact on care plan
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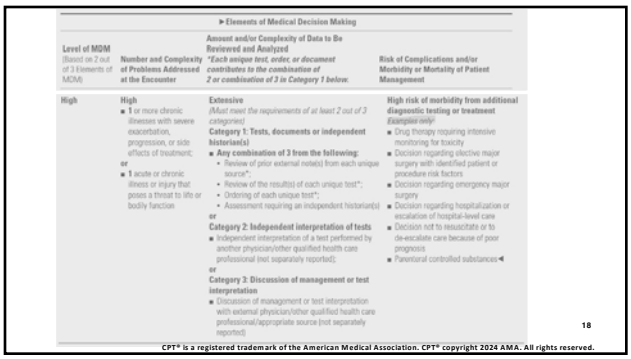
►Elements of Medical Decision Making
Level of MDM (Based on 2 out of 3 Elements of MDM)
Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to Be Reviewed and Analyzed
*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
Risk of Complications and/or Morbidity or Mortality of Patient Management
High
High
■ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
or
■ 1 acute or chronic illness or injury that poses a threat to life or bodily function
Extensive
(Must meet the requirements of at least 2 out of 3 categories)
Category 1: Tests, documents or independent historian(s)
■ Any combination of 3 from the following:
• Review of prior external note(s) from each unique source*;
• Review of the result(s) of each unique test*;
• Ordering of each unique test*;
• Assessment requiring an independent historian(s)
or
Category 2: Independent interpretation of tests
■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
or
Category 3: Discussion of management or test interpretation
■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
High risk of morbidity from additional diagnostic testing or treatment
Examples only:
■ Drug therapy requiring intensive monitoring for toxicity
■ Decision regarding elective major surgery with identified patient or procedure risk factors
■ Decision regarding emergency major surgery
■ Decision regarding hospitalization or escalation of hospital-level care
■ Decision not to resuscitate or to de-escalate care because of poor prognosis
■ Parenteral controlled substances
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Additional HIGH MDM for Nursing Facility

"When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a **high-level MDM type specific to initial nursing facility care** by the ***principal**** physician or other qualified health care professional is recognized. This type is:

"**Multiple morbidities requiring intensive management**: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

"The definitions and requirements related to the amount and/or complexity of data to be reviewed and analyzed and the risk of complications and/or morbidity or mortality of patient management are unchanged."

*The principal/attending physician should append the modifier **–AI** to the initial nursing facility claim to identify as the principal attending physician responsible for the overall care

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Nursing Facility Care Services 2024

Initial Nursing Facility Care

Patient: New or Established			
Code	99221	99222	99223
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	50

Subsequent Nursing Facility Care

Patient: New or Established				
Code	99307	99308	99309	99310
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	20	30	45

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

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Discharge from SNF/NF

- Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code.
- The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date.
- The Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.13

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Nursing Facility Discharge Services

HCPCS Code	Short Description	Natl Pmt Price (2024)	Work RVU
99315	Nf dschrg mgmt 30 min/less	$79.57	1.5
99316	Nf dschrg mgmt 30 min+	$127.70	2.5

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Home *and* Assisted Living Facility Care 2024

(Place of service codes have not changed)

"The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short-term accommodation (eg, hotel, campground, hostel, or cruise ship).

"**These codes are also used when the residence is an assisted living facility**, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility."

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Home Care, Assisted Living, Residential Care Codes Now Combined into a Single Code Set : Home/Residence Visits

HCPCS Code	Short Description	Total Time in Minutes	Level of Medical Decision Making	2024 National Payment Amount	Work RVU
99341	Home/res vst new sf mdm 15	15	Straightforward	$48.13	1
99342	Home/res vst new low mdm 30	30	Low	$76.29	1.65
99344	Home/res vst new mod mdm 60	60	Moderate	$138.51	2.87
99345	Home/res vst new high mdm 75	75	High	$196.79	3.88
99347	Home/res vst est sf mdm 20	20	Straightforward	$44.21	0.9
99348	Home/res vst est low mdm 30	30	Low	$74.66	1.5
99349	Home/res vst est mod mdm 40	40	Moderate	$124.10	2.44
99350	Home/res vst est high mdm 60	60	High	$180.75	3.6

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Best Care Practices In the Post-Acute & Long-Term Care Continuum

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Prolonged Services

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The CY 2023 Physician Fee Schedule Final Rule:

- "G" codes for prolonged services
  - G0316 Prolonged Hospital or Observation Services
  - G0317 Prolonged Nursing Home Services
  - G0318 Prolonged Home or Residence Services
  - G2212 Prolonged Office/outpatient
- Converted Non-face-to-face prolonged service codes 99358-99359 to status "I," i.e. "Not valid for Medicare purposes" or "Ineligible."
- Other CPT Codes for Prolonged Services are not reimbursed by CMS, but may be paid by commercial, Medicaid or some Medicare Advantage payers—check with your payers
- Clarified the time horizon for nursing home prolonged service codes

Medicare Claims Processing Manual, Chapter 12, page 71
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf [26]

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Time Thresholds for Prolonged Services

Primary E/M Service	Prolonged Code*	Service Time (as per code descriptor)	Time Threshold to Report Prolonged Service	Count Physican/NPP time spent within this time period (surveyed time frame)
Initial NF Visit (99306)	G0317	50 mins	95 mins	1 day before visit + date of visit + 3 days after
Subsequent NF visit (99310)	G0317	45 mins	85 mins	1 day before visit + date of visit + 3 days after
NF Discharge Day Mngmt	n/a	n/a	n/a	n/a
Home/Residence Visit New (99345)	G0318	75 mins	140 mins	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. (99350)	G0318	60 mins	110 mins	3 days before visit + date of visit + 7 days after

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

Medicare Claims Processing Manual, Chapter 12, page 71
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf [27]

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G0317

- ***G0317*** *Prolonged* ***nursing facility*** *evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service);*
- *each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact*
  - *(list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services).*
  - *(Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418).*
  - *(Do not report G0317 for any time unit less than 15 minutes)*

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How to Use G0317

- May only be used if reporting the following nursing facility codes, using ***time***:
  - 99306 Initial nursing facility care, per day, 50 minutes must be met or exceeded, *but threshold is 95 minutes to report G0317 X 1*
  - 99310 Subsequent nursing facility care, per day, 45 minutes must be met or exceeded, *but threshold is 85 minutes to report G0317 X 1*
- May be reported for prolonged time within the surveyed time frame:
  - One day before the E&M service
  - On the day of the E&M service
  - Up to 3 days after the E&M service
- May be reported only when the prolonged time equals or exceeds 15 minutes beyond the maximum time specified by the codes
- May be reported for each 15-minute increment beyond the maximum time specified in the codes; ***there is no frequency limitation***
- Includes both face-to-face and non-face-to-face time; may be discontinuous

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G0318

- G0318 *Prolonged* ***home or residence*** *evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service);*
- *each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact*
  - *(list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services).*
  - *(Do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417).*
  - *(Do not report G0318 for any time unit less than 15 minutes).*

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How to Use G0318

- Would be reportable when the total time for the **home or residence** visit (specified in the time file) is exceeded by 15 or more minutes
- Reportable as add on code to:
  - 99345 Home or residence visit for the evaluation of a new patient, 75 minutes must be met or exceeded; *threshold of 140 minutes total to report G0318 X 1*
  - 99350 Home or residence visit for the evaluation of an established patient, 60 minutes must be met or exceeded; *threshold of 110 minutes to report G0318 X 1*
- May be reported for prolonged service(s) spent during:
  - The pre-service 3-days before the E&M visit
  - During the intraservice time on the day of the visit
  - The post-service time up to 7 days after the day of the visit

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When prolonged services for a nursing facility visit (e.g. 99306, 99210) spans several days, what date of service is reported for the prolonged service code G3017?

Answer: In CY 2023, care relative to the initial nursing facility service (99306), and prolonged time for the service (G0317), may occur over a 5-day timespan. This includes the date prior to 99306, the date of on which 99306 is completed and the 3 dates subsequent to the 99306.

For example, 99306 performed on January 5th would include the timespan of January 4th through January 8th for services by the same billing provider/group. Since 99306 requires 95 minutes of time before prolonged service(s) can be added, 99306 may be performed over a period of more than one date. When this is the case, 99306 should be billed for the DOS on which the 95 minute timeframe has been completed. Prolonged services performed beyond the date of 99306 **should be billed with the DOS on which they were completed**, within a 3 day timeframe after the date of 99306.

NOTE: Some payers' systems may not be able to recognize G0317 if the date of service differs from the date of service of the index service, i.e. 99306 or 99310.

https://www.nrsmedicare.com/ca/evaluation-and-management?selectedArticleId=5205244&lob=96664&state=97133&region=93623

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Prolonged Services: Payment and wRVU for 2024

HCPCS Code	Short Description	Non-Facility Price	Facility Price	Work RVU
G0316	Prolong inpt eval add15 m	$31.11	$29.47	0.61
G0317	Prolong nursin fac eval 15m	$31.11	$29.47	0.61
G0318	Prolong home eval add 15m	$30.45	$29.14	0.61

Medicare Claims Processing Manual, Chapter 12, page 71
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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Split Visits

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Split or Shared Visits

30.6.18 - Split (or Shared) Visits
(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)
A. Definition of Split (or Shared) Visit
A split (or shared) visit is an evaluation and management (E/M) visit in the ***facility setting*** *that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.*
Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.

--Medicare Claims Processing Manual, Chapter 12

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Split or Shared Visits

E/M Visit Code Family	Place of Service Code(s), examples	2023 Definition of Substantive Portion	2024 Definition of Substantive Portion
Other Outpatient	05, 09, 22, 24, etc.	History, or exam, or MDM or more than half of total time	More than half the total time OR MDM*
Inpatient/Observation/ Hospital/**SNF**	21, 31	History, or exam, or MDM or more than half of total time	More than half the total time OR MDM*
NF	**32**	Cannot use split visit **or** "incident to"	Cannot use split visit **or** "incident to"
Office	11	Cannot use ("incident to" applies)	Cannot use ("incident to" applies)
Home/Residence	12-16	Cannot use ("incident to" applies)	Cannot use ("incident to" applies)
Emergency Department	23	History, or exam, or MDM or more than half of total time	More than half the total time OR MDM*
Critical Care	23, 21, etc.	More than half of total time	More than half the total time

*Substantive portion of MDM requires clinician made or approved management plan for the **number and complexity of problems addressed at the encounter** and takes responsibility for that plan with its inherent **risk of complications and/or morbidity or mortality of patient management**.

Medicare Claims Processing Manual, Chapter 12, page 73
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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Payment: Fun Facts to Know and Tell!

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What is a medically necessary visit?

- "Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B."—Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners
- "Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor."—CMS at https://www.cms.gov/apps/glossary/search.asp?Term=medically+necessary&Language=English&SubmitTermSrch=Search
- "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."—Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners

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In other words

The visit must be medically necessary AND

The level of service reported must be medically necessary (supported by H&P, MDM etc.)

THEREFORE: **Documentation must support both the medical necessity of the visit itself AND the level of service being reported**

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Mandated regulatory physician visits: Frequency

F712

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.30(c) Frequency of physician visits

- **§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.**
- **§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.**
- **§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.**
- **§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.**

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Mandated regulatory physician visits: Content

DEFINITIONS §483.30(c) Must be seen, for purposes of the visits required by §483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.

--State Operations Manual; Appendix PP—Guidance to Surveyors, page 445. Downloaded on 10/11/2022 from: https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf

IMPLICATIONS

- Though payment policy allows nursing home visits to be performed via Telehealth (payment policy), this does not apply to regulatory visits (federal regulations)
- **Mandated regulatory** visits must be face-to-face
- Other visits may be performed via Telehealth

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Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Recertifications When Permitted by the State

	Initial Comprehensive Visit /Orders	Other Required Visits^	Other Medically Necessary Visits & Orders+	Certification/ Recertification ‡
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State Requirements
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable
PA, NP, & CNS not a facility employee	May perform/ May sign*	May perform	May perform and sign	Not applicable

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

* A NPP may provide admission orders if a physician personally approved in writing a recommendation for admission to the facility prior to admission. For additional requirements on physician recommendation for admission and admission orders, see §483.30(e), F710.

^ Other required visits are the physician visits required by §483.30(c)(1) other than the initial comprehensive visit.

+ Medically necessary visits are independent of required visits and may be performed prior to the initial comprehensive visit.

‡ Though not part of a compliance determination for this section, this requirement is provided for clarification and relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

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Initial Comprehensive Nursing Facility Evaluation vs. Initial Nursing Facility Visit

- **Initial Nursing Facility Services**
  - Refers to CPT Codes 99304-99306
  - May be reported once per admission, per physician or other qualified health care professional
- **Initial Comprehensive Nursing Facility Visit**
  - Refers to the mandated regulatory visit that may only be performed by a physician (with certain exceptions)
  - Must include review of total program of care, including medications and treatments
  - Must be performed within 30 days of admission
  - May be reported with Initial Nursing Facility Services code 99304-99306 + modifier –AI to denote attending physician

Medicare Claims Processing Manual, Chapter 12, page 73
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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If a nurse practitioner or physician assistant performs a history and physical prior to the attending physician's comprehensive visit in a nursing facility, how should these two encounters be coded?

From the Medicare Claims Processing Manual, Chapter 12, Sect. 30.6.13:

- "Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 - 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above)."*

From the 2024 AMA CPT Manual:

- "The principal physician or other qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310)."

*with modifier –AI to denote the primary attending physician

Medicare Claims Processing Manual, Chapter 12, page 73
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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What do I bill upon readmission from a hospitalization?

It depends—

For Medicare Part A Skilled Nursing Facility patients, The SNF PPS includes an "interrupted stay" policy that if a patient in a covered Part A SNF stay is discharged from the SNF but returns to the same SNF no more than three consecutive calendar days after having been discharged, then this would be considered a continuation of the same SNF stay (see 83 FR 39162, 39243). In such cases, no new patient assessments are required…

- Note that MA payers may have different contractual arrangements with facilities

2019 Final Rule 83 FR 39162 https://www.govinfo.gov/app/details/FR-2018-08-08/2018-16570

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R2278OTN.pdf

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Now that 99318 Annual Nursing Home Visit has been deleted, how can I report an annual comprehensive exam?

- May use subsequent nursing facility visit codes 99307-99310, selecting the level by either total time of the visit or medical decision-making
- Alternately, consider incorporating the Medicare Wellness Visit into your practice
- Note: Components of Wellness Exams may not be goal-concordant with frail, elderly nursing home residents; may need to customize components of wellness visits to appropriately meet the needs of nursing home residents

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Nursing Home Admission and Other Visits on the Same Day

- Emergency department visit services provided on the same day as a nursing facility assessment are not paid
- Hospital discharge and nursing facility admission may be reported separately even if performed on the same day
- Payment for evaluation and management services provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date
- Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.13

Medicare Claims Processing Manual, Chapter 12
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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Can I report G2211 with a Nursing Facility Service Code?

- G2211 Ofice/Outpatient Visit Complexity Add-on Service
- Add-on to E&M Service to recognize additional complexities associated with longitudinal patient relationship due to:
  - Primary care **OR**
  - Ongoing medical care of patient with single serious or complex condition
  - Is specialty-agnostic
- May be reported **only** with Office/Outpatient Services 99202-99215
- May **not be** reported with Nursing Facility Services 99304-99310
- May **not be** reported with Home/Residence Services 99341-99350
- May **not be** reported when service with –25 modifier is reported

https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

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What do I bill upon readmission from a hospitalization?

- For long term care Nursing Facility residents it is somewhat unclear…
- Under §483.20(b) Comprehensive Assessments, "For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave."
- From CPT 2024: "Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visit."
- And in the CPT 2024 language to the Initial Nursing Facility Care codes: "Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional regardless of length of stay. They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional."
- And according to the 2023 Physician Fee Schedule Final Rule:
  - "The initial comprehensive assessment required under 42 CFR 483.30(c)(4) will be billed as an initial NF visit (CPT code 99304–99306)."

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

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What do I bill when I assume the care of a patient from another provider?

- Bill an Initial Nursing Facility Care code if assuming care from non-related provider (different practice, different TIN)
- Clarified in the 2024 CPT manual
  - "Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, **per physician** or other qualified health care professional, regardless of length of stay".
  - "An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice *during the stay*".
  - "An initial service may also be reported if the patient is a new patient as defined in the Evaluation and Management Guidelines".

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Questions

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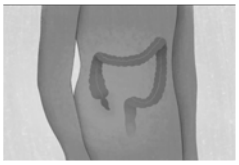
APPENDIX



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Telehealth Services

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Nursing Home Codes and Telehealth - 2024

Code	Short Descriptor	Status
99302	Nursing facility care init	Provisional
99305	Nursing facility care init	Provisional
99306	Nursing facility care init	Provisional
99307	Nursing fac care subseq	Permanent addition – q 14 day limit on hold
99308	Nursing fac care subseq	Permanent addition – q 14 day limit on hold
99309	Nursing fac care subseq	Permanent addition – q 14 day limit on hold
99310	Nursing fac care subseq	Permanent addition – q 14 day limit on hold
99315	Nursing fac discharge day	Provisional
99316	Nursing fac discharge day	Provisional

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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Home and Residence Codes and Telehealth

Code	Short Descriptor	Status
99341	Home visit new patient	Provisional
99342	Home visit new patient	Provisional
~~99343~~	~~Home visit new patient~~	~~Provisional~~ 99343 was deleted
99344	Home visit new patient	Provisional
99345	Home visit new patient	Provisional
99347	Home visit est patient	Permanent
99348	Home visit est patient	Permanent
99349	Home visit est patient	Provisional
99350	Home visit est patient	Temporary Addition until Dec. 31, 2024

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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Other Telehealth provisions of the final rule

- Provided a step-by-step process for evaluating services that could potentially be provided via telehealth (provisional vs. permanent)
- Delayed in-person requirements for telehealth behavioral health services until January 1, 2025
- Continues to allow distant site practitioners to use their currently enrolled practice location instead of home address when providing telehealth services from home
- Allows qualified OT, PT, SLP and audiologists to continue to be included as telehealth practitioners through 12/31/2024
- Recognizes marriage and family therapists (MFT) and mental health counselors) MHC) as telehealth practitioners, effective 1/1/2024

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Prolonged Services

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Time Thresholds to Report Prolonged E&M Services: 2024

Primary E/M Service	Prolonged Code*	Service Time (as per code descriptor)	Time Threshold to Report Prolonged Service	Count Physican/NPP time spent within this time period (surveyed time frame)
Initial NF Visit (99306)	G0317	50 mins	95 mins	1 day before visit + date of visit + 3 days after
Subsequent NF visit (99310)	G0317	45 mins	85 mins	1 day before visit + date of visit + 3 days after
NF Discharge Day Mngmt	n/a	n/a	n/a	n/a
Initial IP/Obs. Visit (99223)	G0316	75 mins	90 mins	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	50 mins	65 mins	Date of visit
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a	n/a
Consults	n/a	n/a	n/a	n/a
Cognitive Assessment and Care Planning (99483)	G2212	60 mins (typical)	100 mins	3 days before visit + date of visit + 7 days after
Home/Residence Visit New (99345)	G0318	75 mins	140 mins	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. (99350)	G0318	60 mins	110 mins	3 days before visit + date of visit + 7 days after

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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Advance Care Planning

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Advanced Care Planning

- Between a physician or other qualified healthcare professional (QHCP) and a patient, family member, or surrogate. Can do audio only.
- Patient does not need to be present
- Counseling and discussing advance directives
- With or without completing relevant legal forms.
- Consent because of co-pay "Is it ok if we talk about your wishes for your care?"

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Examples of Advance Directives

- Health Care Proxy,
- Durable power of attorney for healthcare
- Living will
- Physician Orders for Life-Sustaining Treatment (POLST) or state-specific equivalent.

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Advance care planning payment 2024

HCPCS Code	Short Description	Non-Facility Price	Facility Price	Work RVU
99497	Advncd care plan 30 min	$80.55	$73.35	1.5
99498	Advncd care plan addl 30 min	$69.75	$69.09	1.4

- 99497 : 16-45 minutes (CPT "Halfway" convention)
- 99497 + 99498: 46 – 74 minutes
- Additional 99498: each additional 30 minutes (16 minute minimum)
- Can be billed in addition to the E & M codes:
  - Office/Outpatient
  - Nursing Facility
  - Home/residence
  - Transitional Care Management

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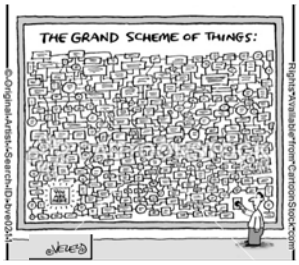
G2211 Office/Outpatient Visit Complexity Add-On Code



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New Office/Outpatient Visit Complexity Code

- Created by CMS and effective January 1, 2024.
- G2211 recognizes additional complexities associated with primary care or ongoing medical care of a patient with a single serious or complex condition—longitudinal relationship
- Most likely use in primary care, but may also be used by specialists with longitudinal relationship with patient
- This add-on code may be reported only with Office/Outpatient evaluation and management (E/M) services 99202-99215; cannot be reported in skilled nursing facility/nursing facility (SNF/NF) or Home/Residence.
- Cannot be reported when services requiring modifier -25 reported
- CMS will pay an additional $16.04 for services reported with G2211.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf 64

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G2211 Office/Outpatient (O/O) Visit Complexity Add-On

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

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Reference Materials

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Name of Service	
AMA Link to 2023 Evaluation and Management CPT Code Revisions	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiTv7DP3NP6AhW4IlkEHSZ-CTsQFnoECBAQAQ&url=https%3A%2F%2Fwww.ama-assn.org%2Fsystem%2Ffiles%2F2023-e-m-descriptors-guidelines.pdf&usg=AOvVaw3602CDkiKKTlCu7BZECisg
CMS Website on COVID-19 Waivers	https://www.cms.gov/coronavirus-waivers
Appendix PP: State Operations Manual—Guidance to Surveyors (All the F-tags and federal regs for nursing facilities)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
CMS List of Covered Telehealth Services	https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
Health and Human Services Telehealth Info	https://www.telehealth.hhs.gov/
CMS COVID-19 Waivers	https://www.cms.gov/coronavirus-waivers

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Name of Service	Where to find the information
Chronic Care Management Services	https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
Cognitive Assessment and Care Services	https://www.alz.org/careplanning/downloads/cms-consensus.pdf
Advance Care Planning Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
2023 Medicare Physician Fee Schedule Final Rule (Source for CMS Prolonged Service 'G' Codes)	https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf
2024 Medicare Physician Fee Schedule Final Rule	https://public-inspection.federalregister.gov/2023-24184.pdf
Care Management Services in Rural Areas	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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Name of Service	Where to find the information
The Initial Preventive Physical Exam ("Welcome to Medicare Visit")	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
Annual Wellness Exam (AWV)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
Incorporating the AWV into the Nursing Facility (This is one example of how to incorporate part of the AWV into nursing home practice)	Little MO, Sanford AM, Malmstrom TK, Traber C, Morley JE. Incorporation of Medicare Annual Wellness Visits into the Routine Clinical Care of Nursing Home Residents. J Am Geriatr Soc. 2020 Dec 18. doi: 10.1111/jgs.16984. Epub ahead of print. PMID: 33339071. https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16984
Transitional Care Management Services	https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management/faq.html (May require membership, password or fee) https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html (May require membership, password or fee)
Behavioral Health Integration Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf
Medicare Physician Fee Schedule Lookup	https://www.cms.gov/medicare/physician-fee-schedule/search

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Documentation, Coding and Billing in PALTC:2024

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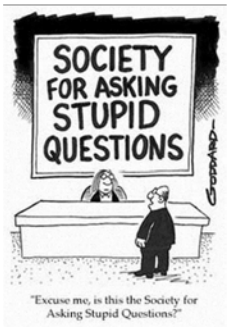

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